

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08443

08439

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bel Air</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		TOWN <u>Bel Air</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>JULIAN C. BLACKLOCK</u>				4. DATE OF DEATH <u>8 24 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>		8. DATE OF BIRTH <u>March 25 1871</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		9. AGE last birthday <u>86</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frederick Sydney Blacklock</u>				14. MOTHER'S MAIDEN NAME <u>Julia Swann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT & ADDRESS <u>J. Sydney Blacklock, Bel Air, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <u>GENERAL VISCERAL FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7-2-57</u>			
ANTECEDENT CAUSE(S) DUE TO <u>GENERALIZED ART SCLEROSIS</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-5-57</u> , to <u>8-24-57</u> , that I last saw the deceased alive on <u>8-14-57</u> , and that death occurred at <u>7 A.M.</u> from the cause and on the date stated above.							
SIGNATURE <u>E. J. Delaney</u>				DATE SIGNED <u>8-24-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>8/27/57</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Rest</u>	
24. REC'D BY REGISTRAR <u>Julia H. Mason</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>		LOCATION (City, town, or county) (State) <u>La Plata, Md.</u>	
DATE <u>8/28/57</u>							

CERTIFICATE OF DEATH

1. Name of deceased: *John J. McDevitt*  
2. Sex: *Male*  
3. Age: *47*  
4. Date of death: *Aug 28 1957*  
5. Place of death: *Home*  
6. Cause of death: *Myocardial infarction*  
7. Duration of illness: *2 days*  
8. Name of physician: *Dr. J. J. McDevitt*  
9. Name of attending physician: *Dr. J. J. McDevitt*  
10. Name of funeral home: *McDevitt Funeral Home*  
11. Name of undertaker: *McDevitt Funeral Home*  
12. Name of cemetery: *St. Mary's Cemetery*  
13. Name of burial place: *St. Mary's Cemetery*  
14. Name of burial place: *St. Mary's Cemetery*  
15. Name of burial place: *St. Mary's Cemetery*

BUREAU V. 2

AUG 30 1957

RECEIVED

8/31/57 MC Devitt  
Hunt  
1957

CERTIFICATE OF DEATH

08444

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>LA PLATA</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRYANTOWN (rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>PHYSICIANS MEMORIAL</b>		e. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Forbes BOWLING</b>		4. DATE OF DEATH Month Day Year <b>Aug. 18 1957</b>	
5. SEX <b>M</b>	6. COLOR OF FACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 20 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
13. FATHER'S NAME <b>Albert Bowling</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Forbes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-974</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) _____		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG. 18 1957</b> to <b>AUG. 23 1957</b> , that I last saw the deceased alive on <b>AUG. 18 1957</b> , and that death occurred at <b>11:35 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. PARRAN PARBOE M.D.</b>		ADDRESS (Street, city or town, state) <b>La Plata Md</b> DATE SIGNED <b>8-19-57</b>	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 21 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's</b>		22d. LOCATION (City, town, or county) (State) <b>Bryantown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home</b>		24. REGISTRAR'S SIGNATURE <b>John H. Bailey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

AUG 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08445

08441

## CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Newport</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stuy Men Hosp</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anthony Chapman</u>		4. DATE OF DEATH Month Day Year <u>Aug 26 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1904</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William F Chapman</u>	
14. MOTHER'S MAIDEN NAME <u>Greene Campbell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW2</u>	
16. SOCIAL SECURITY NO. <u>123-45-6789</u>		17. INFORMANT <u>George Chapman</u> Address <u>Washington DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Neoplasm</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>uncertain</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 August, 1957</u> , to <u>26 August, 1957</u> , that I last saw the deceased alive on <u>24 August, 1957</u> , and that death occurred at <u>5:01 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V. B. Dettor</u> M.D. <u>LA PLATA, MD.</u>		DATE SIGNED <u>27 Aug. 1957</u>	
PHYSICIAN'S NAME (Type) <u>V. B. DETTOR M.D.</u>		<u>LA PLATA, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 29, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Civilington Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Civilington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernestine H. Hays</u> ADDRESS <u>LA PLATA</u>		24a. REC'D BY REGISTRAR DATE <u>8/28/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Julius H. Hays</u>			



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

BUREAU V. 1

AUG 30 1957

RECEIVED

08442

08446/00

CERTIFICATE OF DEATH

Reg. Dist. No.

782

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>				c. LENGTH OF STAY IN 1b <b>30 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BRANDYWINE</b>				d. STREET ADDRESS <b>X1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH SYLVESTER DE LOZIER</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 17 19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 2-1884</b>	
9. AGE (In years last birthday) yrs. <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN WESLEY Buchanan DeLozier</b>				14. MOTHER'S MAIDEN NAME <b>HARRIET THOMPSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give year or dates of service] <b>NO</b>				16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>George A. DeLozier Brandywine, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, STOMACH WITH HEPATIC METASTASES</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 MRS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from <b>APRIL 1956</b> , to <b>AUGUST 17, 1957</b> , that I last saw the deceased alive on <b>AUGUST 17, 1957</b> , and that death occurred at <b>6:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John H. Griffin</b>				ADDRESS (Street, city or town, state) <b>Box #65, Hughesville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>John H. Griffin</b>				DATE SIGNED <b>8/17/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>		22d. LOCATION (City, town, or county) (State) <b>Ridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR <b>8/19/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julia R. Posey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 20 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08447

Reg. Dist. No. 100

08443

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laplate</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Papay Creek</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phy num Hosp</i>				d. STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or print) <i>John Frederick Drinks</i>				4. DATE OF DEATH <i>Aug 16 1957</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 16 1883</i>	9. AGE (In years last birthday) <i>73</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Resturant</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>W. I. A.</i>	
13. FATHER'S NAME <i>Charles J</i>				14. MOTHER'S MAIDEN NAME <i>Rosa C Banger</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>George W Robertson</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Gen Art. Sclerosis</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>8-15-57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>8-15 1957</i> to <i>8-16 1957</i> , that I last saw the deceased alive on <i>8-16 1957</i> , and that death occurred at <i>9:15</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>8-16-57</i> DATE SIGNED							
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.							
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 19 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>		22d. LOCATION (City, town, or county) (State) <i>wayside md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rehert Mc Laplate md.</i> ADDRESS				24a. REC'D BY REGISTRAR <i>8/19/57</i> DATE		24b. REGISTRAR'S SIGNATURE <i>Julia H. Posen</i>	

BUREAU V. 81

JUN 22 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08448

08444

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL ALTON RURAL</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Elizabeth</u>	
		d. STREET ADDRESS <u>460 Newport Road</u>	
3. NAME OF DECEASED (Type or print) First <u>BRADLEY</u> Middle <u>ELMORE</u> Last <u>JR.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-31</u>
9. AGE (In years last birthday) <u>25</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISHERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ATLANTIC NAVIG-VIRGINIA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BRADLEY ELMORE, SR.</u>		14. MOTHER'S MAIDEN NAME <u>CORAENE NOEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Funeral Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Surgical shock</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Compound Fractures-left extremity</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>10 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>STRUCK BY AUTO</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:30 p.m. 8-23 1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>	20f. (City or town) (County) (State) <u>BEL ALTON CHARLES, MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>V.B. DETTOR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V.B. DETTOR M.D.</u>		DATE SIGNED <u>24 August 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edwardsville</u>	22d. LOCATION (City, town, or county) (State) <u>Edwardsville Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wichart Inc. Laplata Md</u>		24a. REC'D BY REGISTRAR DATE <u>8/26/57</u>	24b. REGISTRAR'S SIGNATURE <u>Julia St. Pacey</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please advise the funeral home. To the funeral home, please give this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

BUREAU V. S.

AUG 29 1955

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08449

## 08445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 FILING 9-1-57

Reg. Dist. No. 130

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Issue</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Ignatius Hill</u>				4. DATE OF DEATH Month Day Year <u>Dec 22 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 14 1924</u>		9. AGE (In years last birthday) <u>36</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fishing</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John C. Hill</u>				14. MOTHER'S MAIDEN NAME <u>Viola Kennedy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>25 36 3470</u>			
17. INFORMANT <u>Charles Hill</u>				Address <u>4400 E. Hill</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Recirculation</u> DUE TO (b) <u>Ant. Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>8-22-57</u> <u>??</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard J. McPherson</u>				24a. REC'D BY REGISTRAR DATE <u>8/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Posey</u>	



BUREAU V. S.

AUG 10 1957

RECEIVED

08446

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>W. HARTCO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Richmond</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henric</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henric</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>P.O. Box 460 D</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carlotta</u> <u>Witt</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>17</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-18</u>	9. AGE (in years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>W.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel S. Witt</u>				14. MOTHER'S MAIDEN NAME <u>Julia Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>204-12-0290</u>		17. INFORMANT <u>John F. Bridges</u> Address <u>Henric</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>850X</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Asphyxia</u> DUE TO <u>Asphyxia</u> (c) <u>Asphyxia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asphyxia</u> INTERVAL BETWEEN ONSET AND DEATH <u>8-17-57</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swam from boat which drifted away, he couldn't swim</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>8-17</u> p.m. <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Waterfront</u>		20f. City or town (County) <u>Richmond</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>8/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Bridges</u>				ADDRESS <u>Henric</u>		24a. REC'D BY REGISTRAR <u>8/26/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Julia A. Posey</u>							

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 23 1937

RECEIVED

TO **MARYLAND MEDICAL EXAMINER**: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO **FUNERAL DIRECTOR**: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08447

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08451

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Chas</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Phys. Allen Hosp</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>ELLA</u> First <u>MAKLE</u> Middle <u>MAKLE</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-1-06</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Chapman</u>				14. MOTHER'S MAIDEN NAME <u>Annette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MARY HAGANS</u> Address <u>WALDORF MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>				INTERVAL BETWEEN DEATH AND DEATH <u>8-11-57</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. EDEHEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. J. EDEHEN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST PETERS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WALDORF MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> ADDRESS <u>WALDORF, MD.</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Julius P. Poy</u>	

RECEIVED

AUG 14 1957

BUREAU V. S.



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The below copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 (10M)

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08448

## CERTIFICATE OF DEATH

08452/106

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Indian Head Md</u>		<u>two months</u>		TOWN <u>Pinksburg-Md</u>		<u>06X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>163 B Indian Head Hwy</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Wilbert Isham Randle</u>				<u>8-1-57</u> 19 <u>57</u>			
5. SEX	6. CO. OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White-US</u>	<u>Married</u>	<u>1-29-1875</u> <u>1-29-1875</u>	<u>82</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Minister</u>		<u>Methodist</u>		<u>Warsaw Illinois</u>		<u>US</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Pickett Randle</u>				<u>Nancy Stephenson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>No</u>		<u>None</u>		<u>Janna L. Randle -Son</u>		<u>Indian Head Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>				<u>7-days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u>				<u>Indefinite</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u>				<u>Indefinite</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>4-50-0</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-25-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-1-57</u> , 19 <u>57</u> , and that death occurred at <u>9:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>James L. Randle</u> M.D.				DATE SIGNED <u>8-1-57</u>			
ADDRESS (Street, city, town, state) <u>17-Potomac Ave Indian Head Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-4-57</u>		<u>Jessops Methodist</u>		<u>Sparks, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>AUG 5 1957</u>		<u>Chas Price</u>		<u>J. Scott Brooks</u>		<u>622 York Rd Towson 4, Md.</u>	

BUREAU V. S.

AUG 5 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08449

CERTIFICATE OF DEATH

084535

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE ADAM RICHARDS</b>		4. DATE OF DEATH Month Day Year <b>AUG 10 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 18 1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	9. AGE (In years last birthday) <b>58</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>George W. Richards</b>		14. MOTHER'S MAIDEN NAME <b>Adelaide Downs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>CLARA MAY RICHARDS WALDORF MD.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Apoplexy</b> <b>260 X</b> DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1955</b> to <b>Aug 9 1957</b> , that I last saw the deceased alive on <b>8-9 1957</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>Waldorf MD</b> DATE SIGNED <b>8-10-57</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE S. WEBER M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-12-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST PAUL'S CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>WALDORF MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home</b> ADDRESS <b>WALDORF, MD.</b>		24a. REC'D BY REGISTRAR <b>[Signature]</b> DATE <b>AUG 13 1957</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the deceased certificate be executed within 24 hours after death. Page 1 of 3 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR FORCE

RECEIVED

08454

08450

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>	
c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Elizabeth Roberts</u>		4. DATE OF DEATH Month Day Year <u>Aug. 18 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stanley Murray</u>		14. MOTHER'S MAIDEN NAME <u>Emma Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Heber Roberts, Hughesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE, LEFT</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>_____</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1947</u> to <u>August 1957</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL <u>John N. Griffin</u> M.D. <u>Hughesville, Md.</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug. 24, 1957</u>	<u>Old Fields</u>	<u>Hughesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>Hunt Funeral Home, Waldorf, Md.</u>		DATE <u>8/21/57</u>	<u>Julius R. Pusey</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

UG 23 1957

CHIEF OF BUREAU

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08451

08455, 100  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Le Plata</u>		c. LENGTH OF STAY IN 1b <u>27 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldord</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>6120 Willing</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>Grilly</u> Last <u>Thatcher</u>				4. DATE OF DEATH August 1, 1957 Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Grilly</u>				14. MOTHER'S MAIDEN NAME <u>Margaret R. Plunkett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>P. Phillip</u> Address <u>Baldord, 5120 Willing, 100, 101</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>816X</u> <u>ARTERIO-SCLEROTIC HEART DISEASE (CARDIAC)</u> DUE TO <u>DECOMPENSATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 WKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURES, RIGHT TIBIA AND FIBULA; LEFT TIBIA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>X</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>COLLISION OF VEHICLES (2) ON US ROUTE # 301</u>					
20c. TIME OF INJURY Hour <u>7:35</u> a.m. <u>6/25 1957</u> p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>		20f. (City or town) <u>FAULKNER, CHARLES MARYLAND</u>		(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John H. Griffin</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John H. Griffin, M.D.</u>		ADDRESS <u>Le Plata</u>		DATE SIGNED <u>8/2/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Aug 7, 57 in Le Plata Catholic</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Le Plata Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Le Plata, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard H. Le Plata</u>				ADDRESS <u>Le Plata</u>		24a. REC'D BY REGISTRAR DATE <u>8/7/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia M. Fosey</u>			

MEDICAL CERTIFICATION

BUREAU V. S.

AUG 9 1907

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08452

## CERTIFICATE OF DEATH

Reg. Dist. No.

08456

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Newport</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Newport</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS <u>La Plata</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Diana</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 27, 1957</u>		9. AGE (In years last birthday) yrs. <u>12</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>12</u> Days <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ryland</u>		11. BIRTHPLACE (State or foreign country) <u>ryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Da</u>	
13. FATHER'S NAME <u>Joseph Andrew Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clementine Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph A. Thomas, Newport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> <u>102.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>La Plata Md.</u> <u>28 Aug 57</u>							
ACTUAL SIGNATURE <u>A. O. Woody</u>		M.D. <u>La Plata Md.</u>					
PHYSICIAN'S NAME (Type) <u>A. O. Woody</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Newport</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. O. Woody</u>				ADDRESS <u>Newport, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/29/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia H. Pasen</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 3 1957

BUREAU V. S.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08453

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 219 8-30-57 et

CERTIFICATE OF DEATH

08457

Reg. Dist. No.

105

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mollie</u> <u>Wood</u>				4. DATE OF DEATH Month Day Year <u>Aug</u> <u>14</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 12 1893</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Louisa DeBure</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Ada Green</u>		Address <u>Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cerebral Vascular Rupture Dis</u> DUE TO (c) <u>Alcoholism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> <u>1957</u> , to <u>Aug 14</u> , <u>1957</u> , that I last saw the deceased alive on <u>Aug 12</u> , <u>1957</u> , and that death occurred at <u>3:05 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Robert H. DeBure</u> M.D. <u>Baltimore, Md</u> <u>8-16-57</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Aug 12 1957</u>		<u>St Marys</u>		<u>Piscataway Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt</u>				ADDRESS <u>Waldorf, Md.</u>		24a. RECEIVED BY REGISTRAR DATE <u>AUG 15 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>M.L. Monroe</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
CERTIFICATE OF DEATH

200  
100  
Gordon H. Hargis  
Gordon H. Hargis  
Gordon H. Hargis

BUREAU V. 2

AUG 19 1957

RECEIVED

08454

## CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> <u>St. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville, Md. 18x12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Daniel F.</u> Middle <u>ZOOK</u> Last <u>ZOOK</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 30/1883</u>
9. AGE (In years, last birthday) yrs. <u>74</u>		IF UNDER 1 YEAR Months <u>18</u> Days <u>12</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Simeon Zook</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NEVER</u>		16. SOCIAL SECURITY NO. <u>XXXXXXXX</u>	
17. INFORMANT <u>wife &amp; brother</u>		Address <u>Mechanicsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>associated &amp; Bronchial Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 YRS</u> <u>20+ YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 13</u> , 1957, to <u>Aug 23</u> , 1957, that I last saw the deceased alive on <u>Aug 23</u> , 1957, and that death occurred at <u>1:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harmon Jarboe</u> M.D.		ADDRESS (Street, city or town, state) <u>La Plata, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. PARBAN JARBOE M.D.</u>		DATE SIGNED <u>8-23-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Amish Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Mechanicsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/26/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Alfred D. Hancock</u> <u>John P. Mayo</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

AUG 27 1957

RECEIVED